

**U.S. DEPARTMENT OF ENERGY
2014 National Science Bowl®**

**Adult Confidential Medical Information and Emergency Notification Form
(Please fill out the entire 3-page form)**

This is a PDF Form filler document. Click on the space and type in the information requested. Once the form is complete: (1) click "File," then "Save As" and give it a name and save it on your computer; (2) print the completed form; (3) please sign the form in blue ink.

Coach Co-coach NSB Alumnus Regional Coordinator Other

School _____

Name _____ Birth Date _____ Sex: M F

Street Address _____

City _____ State _____ Zip Code _____

Home Telephone () _____

PLEASE LIST TWO EMERGENCY CONTACTS:

	Primary Contact		Contact #2
Name:		Name:	
Phone:		Phone:	
Cell Phone:		Cell Phone:	
Relationship:		Relationship:	

Allergies

Yes No

If Yes, specify:

 Medication _____

 Food _____

 Environmental _____

Medical History (To include surgeries)

Date of Last Tetanus Shot: _____

(A) Current/Recent Medical History/surgery (within the past 12 months)

(B) Previous Medical History/surgery (please include ALL medical history beyond 12 months)

Medication Information (Prescribed and Over-the-Counter Medications and Purpose)

Please follow the format listed below.

Current Prescribed Medications – PLEASE PRINT!

Medication/Dosage	Purpose/Used For
(Example: Albuterol/10mg per day)	(Example: Asthma)

Current Over the Counter Medications – PLEASE PRINT!

Medication	Purpose/Used For
(Example: Advil/as needed)	(Example: Headaches)

Physical Limitations/Needs (Please include any assistive devices that need to be provided):

Mobility Limitations _____

Visual Limitations _____

Communications Limitations _____

Dietary Restrictions (vegetarian, kosher, etc.): _____

Religious or Cultural concerns that may affect care: (e.g. No Blood Transfusions) _____

PHYSICIAN & HEALTH INSURANCE

Physician's Name: _____ Phone Number: _____

Do you have Health Insurance? YES _____ NO _____

If Yes, complete the following:

Insurance Company: _____

Policy Number: _____ Phone Number: _____

CONSENT TO MEDICAL CARE AND TREATMENT

I hereby authorize and consent to the administration of all medical and/or surgical treatment(s) by a licensed physician, nurse or hospital in the event I am not available to consult with the attending physician(s), and the attending physician(s) deem it advisable to proceed with such treatment(s).

(Print Name)

Signature in Ink Date _____

For the National Science Bowl® regional event, please return the completed form to the Regional Coordinator.

Science Bowl
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